

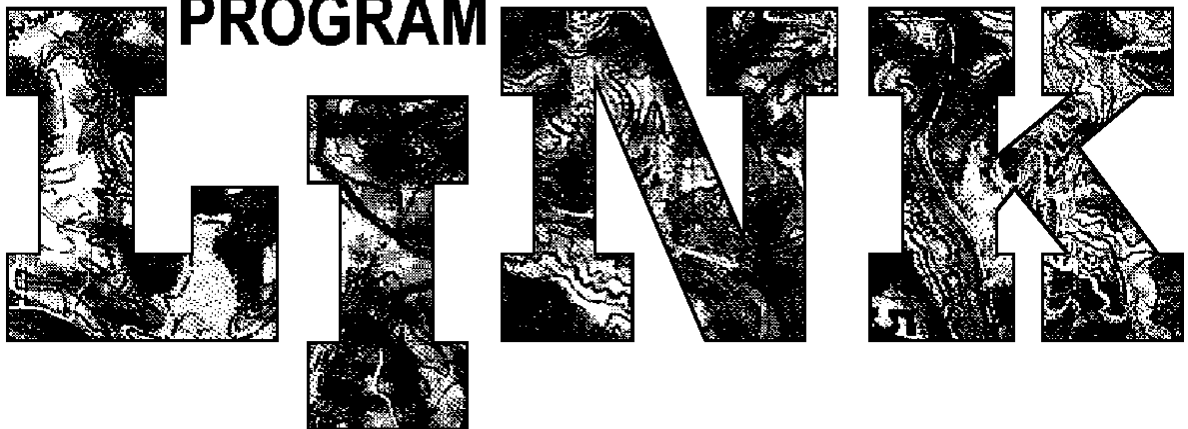
*AETC PAMPHLET 44-102*

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*Medical*

***A SUICIDE PREVENTION AND INTERVENTION  
GUIDE FOR SUPERVISORY PERSONNEL***

**THE AETC  
SUICIDE  
PREVENTION  
PROGRAM**



# AETC LINK PROGRAM

Look for possible concerns

Inquire about concerns

Note level of risk

Know referral resources and strategies

## A Suicide Prevention and Intervention Guide for Supervisory Personnel

This pamphlet, AETCPAM 44-102, implements AFD 44-1, *Medical Operations*.

**The AETC Link Program was designed as a preventative effort to develop a “web” which links individuals, supervisors, first sergeants, commanders, the community, and medical professionals to create concentric circles of concern.**

Suicide was the leading cause of death for AETC enlisted personnel from 1990 through 1993 and the second leading cause of death for 1994. It is said that each suicide intimately affects at least six other people. Suicide is not only a tragic loss of life; it is also disruptive to the surviving members of the military community. Suicide can also have a direct impact on the mission sustainability through the loss of the victim, his or her productivity, and the associated disruption the suicide causes. Finally, this loss also includes the economic value invested in the victim, the associated death benefits, the loss of anticipated contribution to the mission, and the cost of replacement.

The AETC LINK Program was designed as a preventative effort to develop a “web” which links individuals, supervisors, first sergeants, commanders, the community, and medical professionals to create concentric circles of concern. Most suicidal individuals want to live, but many are unable to see alternatives to their problems. They often view their situation as hopeless. We must “link” personnel to helping resources and alternatives once we become aware of the need.

Even though mental health intervention is effective and important in these cases, its major shortcoming lies in the fact that the healthcare system can only act if it is aware of the problem. This places the responsibility on individuals to seek help on their own or be referred by others. Sadly, we have fallen short in this area. Two-thirds of the active-duty Air Force suicide victims studied from 1983 through 1993 had not come in contact with the healthcare system.

To turn this around, buddy care must flourish, with early identification and referral of potentially at-risk personnel by those who perhaps know them best--their friends and coworkers. In addition, supervisory personnel are the initial point of referral in most cases and must act as a gateway to the helping resources for their personnel.

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Each of us is responsible for showing the way. This guide will explain the AETC LINK Program and serve as a ready reference for carrying it out at the squadron level.

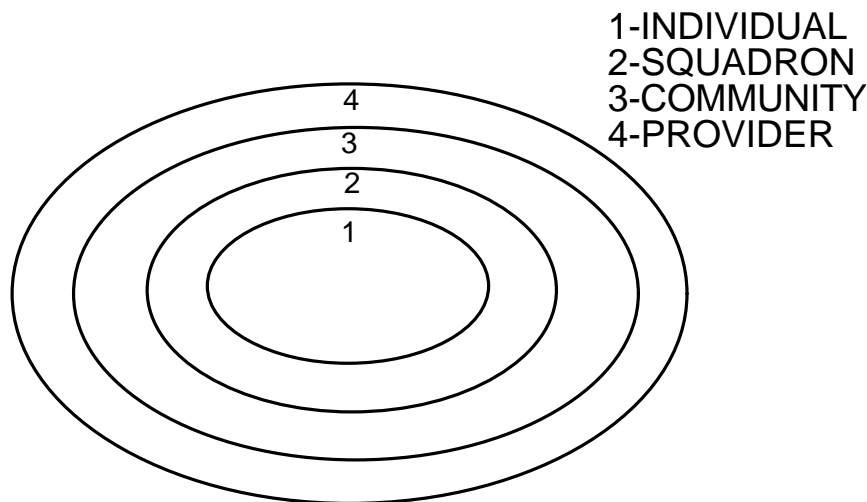
### THE LINK INTERVENTION MODEL

A model is a helpful way to depict a program and give a big picture outlook. Understanding the program and how all the parts fit together is essential to its effective implementation. The model is essentially like a spider web. A spider web interlocks one strand with the next, in effect creating concentric circles. No matter where it is touched, the web's movement signals corresponding action by the spider.

The model should do the same. It surrounds the base community in linked circles of concern, which prompt appropriate corresponding actions no matter where one enters the "web." The total strength of this web is based on the contribution of the individual strands. Each supervisor is a critical strand in the sense that each serves as a first line of defense for the early identification and referral of their personnel who might be at risk.

As the model depicts, there are four levels of intervention, each with different intervention strategies. These levels are the individual, the squadron, the community, and the provider.

### CONCENTRIC INTERVENTION MODEL



#### LEVEL 1-INDIVIDUAL

The primary theme of level 1 is *buddy care*. Awareness training with emphasis on stress and suicide risk factors will be conducted for all personnel. This training is conducted at the first

duty station and all levels of PME. Other personnel are trained through squadron-specific awareness training conducted in small groups. The purpose of the training is to encourage the early identification and referral of potentially at-risk individuals to supervisory personnel in level 2.

## LEVEL 2--SQUADRON GATEKEEPERS

The primary themes of level 2 are *triage and mentoring*. Specific initial and annual refresher training is conducted for commanders and first sergeants in the identification and referral of at-risk personnel, squadron-level risk management programs, and managing organizational stress. Training is conducted at least annually for all supervisory personnel to help identify and refer potentially at-risk personnel. Once these at-risk individuals are identified, they can be referred to the appropriate helping resources.

The purpose of this training is to equip squadron supervisory personnel with the tools necessary to act as gatekeepers, lowering barriers to self-referral and destigmatizing help-seeking behavior through changing the corporate culture. Mentoring at the supervisory level will assist in this effort and is a natural complement to the “buddy care” concept encouraged at the individual level. Referrals should be made to community resources within level 3, such as family support center or chaplains, or directly to level 4, mental health professionals, as in the case of emergency referrals of at-risk personnel.

## LEVEL 3--COMMUNITY GATEKEEPERS

The primary theme of level 3 is *network*. A base helping-professions team is established to network and coordinate service delivery. These individuals are also trained in the identification and referral of potentially at-risk personnel. A base-level critical incident response team formed from these individuals will also assist personnel in the event of a natural disaster, major accident, suicide, or other potentially traumatic event. A Behavioral Health Survey is being developed to assess the organizational culture and target squadron-specific risk factors. The results of this squadron level assessment are reported to squadron commanders to assist with the development of squadron-specific intervention strategies. The base Health Promotions Working Group monitors nonsquadron-specific aggregate results for base stress climate assessment purposes.

## LEVEL 4--MEDICAL PROFESSIONALS

The primary theme of level 4 is *to provide care*. All applicable medical providers are also trained in the identification and referral of at-risk personnel. Mental health personnel make regular field visits to squadrons so that prevention activities such as stress management can be delivered in the organization. Mental health personnel provide consultation services to the commander in the area of managing organizational behavior and stress. Also, squadron-specific awareness training discussed previously in level 1 will be conducted during these field visits.

### KNOW THE FACTS

1. Suicides can be prevented. Most suicidal persons want to live; they are just unable to see alternatives to their problems. They often view their situation as **HOPELESS**.
2. Most often, suicidal persons are temporarily overwhelmed with real **LIFE EVENTS**. Some of the most commonly experienced are relationship difficulties, separation, divorce, financial problems, pending legal or administrative actions, investigation, work problems, loss of a loved one, major illness, etc.
3. Most suicidal persons give definite **WARNINGS** of their suicidal intentions, but we are often unaware of the significance of these or do not know how to respond.
4. Suicide cuts across all ranks, ages, and economic, social, religious, and ethnic boundaries.
5. Suicide is the eighth leading cause of death in the US and the third leading cause among 15- to 24-year-olds, behind accidents and homicide.
6. Males commit suicide at rates and numbers three to four times that of females.
7. Although there are no official US statistics on suicide attempts, it is estimated there are at least 8 to 20 attempts for each death by suicide.

8. Females have been generally found to make three to four times as many attempts as males.

9. Feelings of HOPELESSNESS, such as “there are no solutions to my problem,” are found to be more predictive of suicide than a diagnosis of depression per se.

10. The SOCIALLY ISOLATED are generally found to be at high risk for suicide.

11. It is estimated that suicide intimately affects at least six other people.

12. People with a mental health diagnosis are generally associated with higher risk of suicide. Groups at particular risk are the depressed, schizophrenics, alcoholics, and those with a panic disorder.

13. Currently, there are more than 30,000 suicides annually nationwide (83 per day, one every 17 minutes), with more than 12 of every 100,000 Americans killing themselves.

14. Firearms are currently the most utilized method of suicide.

15. Suicide ranked as the leading cause of death from 1990 to 1993 among enlisted members in AETC and was the second leading cause in 1994.

### **BE AWARE OF THE WARNING SIGNS**

There is no typical suicidal person, but there are some common warning signs. When you act on these warning systems, you can save a life. A suicidal person may:

- Talk about committing suicide
- Have trouble eating or sleeping
- Experience drastic changes in behavior
- Withdraw from friends or social activities
- Lose interest in hobbies, work, school, etc.
- Prepare for death by making final arrangements
- Give away prized possessions

- Have attempted suicide before
- Take unnecessary risks
- Have had a recent or severe loss
- Be preoccupied with death and dying
- Lose interest in his or her personal appearance
- Increase his or her use of alcohol or drugs

### **BE AWARE OF FEELINGS**

Many people have had thoughts about suicide at some point in their lives. Most decide to live because they come to realize the crisis is temporary and death isn't. On the other hand, people having a crisis often feel their situation is inescapable and feel a sense of hopelessness and loss of control. Some commonly experienced feelings are:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat, or work
- Can't get out of depression
- Can't make sadness go away
- Can't see a future without pain
- Can't see themselves as worthwhile
- Can't seem to get someone's attention
- Can't seem to get control

### **BE AWARE OF DO'S AND DON'TS**

- Be aware. Learn the warnings signs.
- Get involved. Become available. Show interest and support.
- Ask if they are thinking about suicide.
- Be direct. Talk openly about their suicidal thoughts. Determine if they have a plan.
- Question accessibility to guns, pills, etc.

- Listen. Allow expression of feelings.
- Don't lecture or debate; try to be nonjudgmental.
- Don't dare them to do it.
- Don't give advice.
- Don't put them off--take all threats seriously.
- Offer empathy, not sympathy.
- Don't act shocked. This will put distance between them and you.
- Don't be sworn to secrecy. Seek support.

**If you are concerned about an individual you feel may be at risk, get help immediately. Don't leave the person alone.**

- Offer hope that alternatives are available. Take action. Remove means, if possible.
- Don't leave the person alone. Get help immediately.

### **WHAT TO DO--LONG TERM**

PROMOTE unit-wide sensitivity to potential risk factors. Unit members should be encouraged to talk to their supervisors, first sergeants, or commanders when they feel the need without fear of retribution.

BE ALERT to factors that may cause stress in your subordinates. Take care of your people.

KNOW your people. Be aware of changes in their attitude, behaviors, and (or) performance.

IDENTIFY at-risk personnel. Be on the lookout for individuals who appear to have problems and get help for them. Don't place those who are determined at risk in demanding situations or where they cannot be observed.

BE CONCERNED about the welfare and morale of your people. If you are aware of personnel experiencing significant life events, show an interest and ask how they are doing frequently and regularly. Don't underestimate the significance of these events.

COMMUNICATE with your people. STOP moralizing and providing easy solutions.

LOOK for nonverbal cues and inconsistency between what is said and what is done.

LISTEN for the feelings behind the words--feelings of despair/hopelessness should prompt immediate concern.

BE AVAILABLE AND SUPPORTIVE. Manage by walking around to get an "eyes on" your people and their situation and to allow them access to you. Act to get help or services for your people and go with them if necessary.

### **WHAT TO DO--IMMEDIATELY!**

If you are concerned about an individual you feel may be at risk, get help immediately. Don't leave the person alone. Bring them to the attention of the squadron commander or first sergeant. Be up front with them and communicate your concerns and what you are doing to get them help. If it is determined they need an immediate emergency referral to mental health, go with them. Besides helping the provider understand the situations and (or) behaviors which prompted the referral, it sends a powerful message to your people that you care.

If you encounter a suicide in progress, get help immediately through the hospital emergency room or 911. Remain calm and stay with the individual until help arrives. If the individual has a dangerous weapon or firearm, don't be a hero. Remember, the suicidal person is emotionally out of control so in this situation your life may also be in danger.

### **CLUSTERING**

One risk factor that has emerged from research on the suicide is suicide "contagion" or cluster effect. This is a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide. Although this concept is not easily understood, it appears that any given community has

an at-risk population of people who are more than a casual risk for suicide. Most of these people are perhaps ambivalent about taking their lives. They may think about suicide frequently, but have not committed to a plan to act. However, if another person commits suicide, especially if the other person was viewed as someone like himself or herself, this reinforces the idea that suicide is an option.

Research indicates the effect of contagion appears to be strongest among younger age groups. If this is true, there is a powerful incentive to be especially mindful of the need for preventive interventions in the wake of a completed suicide. The following suggestions should be considered:

- Inform unit members of the basic circumstances of the suicide.
- Don't talk directly about the act. Too much detail may serve as a "how to" description.
- Seek the assistance of chaplains and other helping professionals.
- Request a critical-incident stress debriefing from mental health professionals.
- Conduct personal interviews with members of the unit who may be most seriously affected by this event.
- Don't glorify the suicide victim's positive characteristics. If the suicide victim's *problems* are not acknowledged in the presence of laudatory statements, suicidal behavior may appear attractive to others at risk, especially those who rarely receive positive reinforcement for *desirable* behaviors.
- Understand that some characteristics of news coverage of suicide may contribute to the contagion. All parties should understand that a scientific basis exists for concern that news coverage of suicide may contribute to the cause of other suicides.
- Don't present simplistic explanations. The final precipitating event is rarely the only cause and shouldn't be seen as a tool for accomplishing certain ends. The majority of victims had multiple factors

which contributed to their situation. Just acknowledging this without significant detail is helpful.

- Don't engage in repetitive, ongoing discussions of the suicide.

## RISK MANAGEMENT

As mentioned previously, no one is immune to being potentially at risk for suicide. There is no typical victim, but we do know that victims have experienced life events they interpret as being overwhelming or hopeless. The attached Military Life Survey should be used to think about potential life event stressors you or your people might be experiencing.

Persons who score under 200 points on this scale are likely to be experiencing good physical and emotional health. Those who score between 200 and 400 points should be encouraged to enroll in a stress management program. You should increase your involvement with these people and look for possible concerns that might indicate risk.

Persons who score more than 400 points should be strongly encouraged to seek counseling services or enter a formal stress management class as soon as possible. Those who seem to be experiencing significant multiple life events should be brought to the attention of the commander or first sergeant for further review.

The point values are only crude indicators of possible concern. This concern should be followed by personal engagement with these personnel to determine how they are handling these events, with referrals to helping resources as needed. How do you talk to someone about your concerns after you determine they rank very high on the survey? Again, this is not an exact science, but the following could serve as an outline:

EVENT. Discuss the events that concern you and listen for other potential events you are unaware of. For example, "I heard about the loss of your mother and was concerned. How are you doing with this?"

INTERPRETATION OR MEANING. No two individuals interpret events the same way. When a person interprets an event as being hopeless, it is often indicative of potential risk. An inquiry should be made to determine how the person interprets these events and what these events mean to him or her.

THOUGHTS. Frequently, based upon their interpretation, individuals have thought about potential actions based on these meanings or beliefs about their situation/interpretation. Again, asking what they have thought about as a result should be pursued.

FEELINGS. Many behaviors are preceded by a feeling or emotion, particularly suicide. Again, following this line of conversation, inquire how they have been feeling as a result.

PLAN. Determine how the person plans to handle this situation. If he or she has potential suicidal thoughts, the following questions need to be asked very clearly: “Have you thought about suicide? Do you have a plan?” Also determine the accessibility to means. Again, if there is any doubt, the person should be referred to the squadron commander or first sergeant immediately. If after duty hours, contact appropriate helping resources: hospital emergency room, 911, Security Police, etc. DO NOT LEAVE THE PERSON ALONE.

## **VOICING YOUR CONCERNS**

The following is a brief example of how to voice your concerns:

SUPERVISOR: “John, I heard about your recent divorce. How are you handling it?”

JOHN: “Not good, especially due to the financial hardships it has created and the fact that I don’t get to see my kids like I used to. I guess since my dad died last month, I don’t really have anyone to talk to.”

SUPERVISOR: “I’m really concerned about you. You mentioned some very significant losses. What do these mean to you?”

JOHN: “I don’t see any future for myself. It seems hopeless with all that’s on me right now.”

SUPERVISOR: “You mentioned feeling hopeless and no sense of a future. What have you been thinking about lately?”

JOHN: “Actually, all I think about is how unfair life is. What did I do to deserve this?”

SUPERVISOR: “How do you feel inside right now?”

JOHN: “I feel sad, numb. In fact, I don’t know if I have any more feelings at all.”

SUPERVISOR: “What have you thought about doing to deal with all this?”

JOHN: “I feel like ending it all. I would just like to go to sleep and never wake up.”

SUPERVISOR: “Do you feel like killing yourself?”

JOHN: “Yea. In fact, I think about it a lot.”

SUPERVISOR: “Do you have a plan?”

JOHN: “I bought a gun yesterday. I thought about driving up to the lake, getting by myself, and then doing it.”

SUPERVISOR: “John, I don’t want you to do that. I am concerned and want to help. I want us to talk to the first sergeant about your situation right now. I know she would be concerned, too. Will you go with me?”

JOHN: “Yea, I guess. I just don’t know what else to do.”

WALTER A. DIVERS, JR., Colonel, USAF, MC  
Director of Medical Services and Training

***Attachment***  
Military Life Survey

**MILITARY LIFE SURVEY**

<i>RANK</i>	<i>MILITARY LIFE EVENT</i>	<i>VALUE</i>
1	Death of Spouse .....	100
2	Divorce.....	73
3	Marital Separation or Remote Tour.....	65
4	Suicide of a Family Member or Close Friend.....	63
5	Death of a Close Family Member.....	63
6	Personal Injury or Illness .....	53
7	Marriage.....	50
8	Reduction in Rank .....	47
9	Marital Reconciliation or Reunion From Long Tour or TDY .....	45
10	Retirement, Separation, or PCS (Desired or Not).....	45
11	Change in Family Member's Health.....	44
12	Pregnancy (Desired or Not) .....	40
13	Significant Emotional Distress, such as Depression, Anxiety, Anger, etc. ....	39
14	Addition to Family .....	39
15	Frequent TDYs .....	39
16	Change in Financial Status .....	38
17	Death of a Close Friend .....	37
18	Voluntary or Involuntary Cross-Training .....	36
19	Change in Number of Marital Arguments .....	35
20	Mortgage or Loan Over \$50,000 .....	31
21	Harsh Air Force Disciplinary Action.....	30
22	Change in Work Responsibilities .....	29
23	Son or Daughter Leaving Home .....	29
24	Trouble with In-Laws .....	29
25	Outstanding Personal or Military Achievement .....	28
26	Spouse Begins or Stops Work .....	26
27	Starting or Ending Civilian or Military School .....	26
28	Change in Living Conditions.....	25
29	Revision of Personal Habits, such as Smoking or Drinking.....	24
30	Trouble With Chain of Command .....	23
31	Change in Work Hours or Conditions .....	20
32	Change in Local Residence.....	20
33	Change in Schools, Self or Family Member.....	20
34	Change in Recreational Habits .....	19
35	Change in Church Activities.....	19
36	Change in Social Activities .....	18
37	Mortgage or Loan Under \$50,000 .....	17
38	Change in Sleeping Habits or Quality .....	16
39	Trouble With Air Force or Civilian Coworkers .....	15
40	Change in Eating Habits, Gained or Lost Weight .....	15
41	Annual Leave.....	13
42	Religious Holiday Season.....	12
43	Minor Air Force Disciplinary Action .....	11
<b>TOTAL</b>		<b>_____</b>